PATIENT INFORMATION

PATIENT NAME_____

ADDRESS_____

CITY, STATE, ZIP_____

TELEPHONE #'S: HOME_____**CELL**_____

EMAIL: _____

Driver's License Number: _____ **Date of Birth**_____

Spouse/Partner: _____

Whom can we thank for referring you? _____

DENTAL HISTORY

Do you have any CURRENT DENTAL CONCERNS? _____

Date of last visit: _____

When were your last x-rays taken? _____

Former Dentist and phone number_____

Have you ever had an adverse reaction to dental anesthetic? Y/N _____

Do you premedicate before dental treatment? _____

DENTAL INSURANCE INFORMATION

POLICYHOLDER NAME & ID/SSN_____

EMPLOYER_____

INSURANCE CO & GROUP #_____

INSURANCE MAILING ADDRESS_____

MEDICAL HISTORY

Your Physician: _____ Date of last visit: _____
Have you had any serious illness or operation Y/N
If yes, explain _____
Have you ever taken BISPHOSPHONATES? (Boniva, Fosamax, etc.) _____
Are you PREGNANT? _____
Do you use cigars, cigarettes, pipe, or chewing tobacco? _____
Do you have any CURRENT HEALTH CONDITIONS? _____
List Current Medications: _____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD, OR NOW HAVE:

AIDS/HIV	Arthritis	Surgical Implant	Anemia
Diabetes	Psychiatric Care	Hip or Knee Replacement	Shortness of Breath
Eating Disorder	Food Allergies	Pacemaker/Heart Surgery	Jaw pain
Hemophilia (abnormal bleeding)	Rapid Weight Loss/Gain	Atopic Dermatitis -allergy prone	Cancer
Acid Reflux	Tuberculosis	Mitral Valve Prolapse	Radiation Treatment
Epilepsy	Glaucoma	Heart Murmur	Ulcer/Colitis
Anaphylaxis	Artificial joints	Rheumatic Fever/Scarlet Fever	Tonsillitis
Fainting	Asthma	Respiratory Disease	Nervous Problems
Back Problems	Spina Bifida	Stroke	Cough-persistent
Hepatitis	Cholesterol	High Blood Pressure	Cough Up Blood
Herpes		Swelling (feet/ankles)	Liver Disease
Blood Disease	Shingles	Kidney Disease/Malfunction	HPV
Tobacco Habit	Skin Rash	Artificial Heart Valves	
Cortisone Treatments	Chemical Dependency	Thyroid Disease	

Heart Conditions -please describe_____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING? Please circle

Aspirin	Erythromycin	Local Anesthetic	Nitrous Oxide
Codeine	Penicillin	Sulfa	Latex

Other Allergies_____
SIGNATURE_____DATE_____

Review Medical Information, Note Changes

Initial & Date _____
Initial & Date _____
Initial & Date _____

Philip Bradford DDS
Family and Sedation Dentistry
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619-295-3128

Dear Patients,

We realize your time is very valuable and out of respect for that we never double book appointments and strive to follow the schedule to the best of our ability. Our after-hours emergency number is always available for weekends and whenever the office is closed. Our answering machine is always on for calls made to the office.

It is our office policy to require at least 24 hour notice if an appointment is to be changed or cancelled. Changes made without 24 hour notice or missed appointments will incur a 25-dollar charge. We will give a reminder call the day before the appointment.

Thank you for letting us care for your oral health. By minimizing schedule mishaps, we can maximize our time spent caring for you.

Thank you very much for your cooperation.

Dr. Bradford
And Staff

Patient Signature_____
Date_____

FINANCIAL GUIDELINES

As a courtesy to you, we will complete and file insurance forms for your dental treatment.
You are responsible for verifying benefits and coverage percentages.
The estimated amount the insurance company will not cover is due at time of treatment unless prior arrangements are made. Charges for patients without insurance coverage are due at the time of treatment unless prior arrangements are made. Charges not paid within 60 days are subject to a finance charge of 1.50% per month (18% annual rate).

AUTHORIZATION AND RELEASE

I authorize the release of any information to third party payors and/or health practitioners. I authorize payment from my insurance company to be issued directly to Dr. Bradford. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf. I certify I have read and understand the above information and the information I have provided is accurate.

X_____ _____

Signature of patient Date